

**DEPARTMENT OF SOCIAL SERVICES**  
DIVISION OF ECONOMIC ASSISTANCE



RE: Wage Information For

Dear

The individual named above has authorized the release of information to the Department of Social Services (DSS). Please complete the reverse side of this form and return it in the enclosed stamped, self-addressed envelope or by faxing it to our office if there is a number listed above.

Through coordinated efforts of the DSS and South Dakota Career Centers, our programs have increased responsibility in:

- ♦ Helping adults who are able to work become employed and/or stay employed; and
- ♦ Accurately reflecting income received by individuals on our programs to reduce the risk of a financial sanction against the State of South Dakota.

Please feel free to contact me if you have questions. Thank you for your anticipated cooperation.

Sincerely,

Economic Assistance Benefits Specialist

**WAGE VERIFICATION – Please Return To:**

Fax #

I AUTHORIZE THE RELEASE OF THIS INFORMATION TO THE DEPARTMENT OF SOCIAL SERVICES.

(EMPLOYEE SIGNATURE)

Please complete all sections as indicated for \_\_\_\_\_

Employee Name

Social Security Number

**Skip this Section      Complete this Section**

1. He/she received the following earnings for the time frame \_\_\_\_\_ through \_\_\_\_\_.  
Please report on this form using fields below or submit payroll records, computer printouts, prints of computer screens, or copies of the pay stubs.

Date RECEIVED by Employee	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
Hours Worked	_____ hrs				
GROSS Earnings	\$_____	\$_____	\$_____	\$_____	\$_____
TIPS – list only if not in gross	\$_____	\$_____	\$_____	\$_____	\$_____
Child Support Deducted	\$_____	\$_____	\$_____	\$_____	\$_____
NET Earnings	\$_____	\$_____	\$_____	\$_____	\$_____

**Skip this Section      Complete this Section**

2. Employment began on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_. First pay received or to be received \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_.  
Pay checks received on  Mon  Tues  Wed  Thurs  Fri  Sat  Sun

Paid  Weekly  Bi-Weekly  Twice a Month  Monthly  Other \_\_\_\_\_

He/she will work approximately \_\_\_\_\_ hours per week at \$\_\_\_\_\_ per hour.

- Is this under Workforce Investment Act (WIA)?  Yes-On the Job Training  Yes-Work Experience  No
- Is this graduate assistantship or stipend?  Yes  No
- Is this job expected to last at least 120 days?  Yes  No

**Skip this Section      Complete this Section**

3. Do you anticipate any increases or decreases in hours or pay?  Yes  No If yes, please explain: \_\_\_\_\_

Did the employee cause a reduction in hours?  Yes  No Were increased hours refused?  Yes  No

**Skip this Section      Complete this Section**

4. For employment that has ended: Last date of employment was \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_.  
Last check was or will be received on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ for Gross Amount \$\_\_\_\_\_.

Reason the job ended:

Quit  Laid off  Fired  Failed to show up for work  
 Medical leave  Maternity leave  Work was temporary  Other \_\_\_\_\_

- Did employment end due to a layoff or temporary suspension?  Yes  No If yes, please indicate the date you anticipate calling the employee back to work \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_.
- Will the employee receive any other compensation such as vacation or severance pay, 401K, retirement, etc.?  Yes  No If yes, \$\_\_\_\_\_ gross amount and \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ date available.

**Skip this Section      Complete this Section**

5. Health insurance information: Name of insurance company: \_\_\_\_\_

Insurance not offered or not purchased by employee  
 Current coverage start date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ policy # \_\_\_\_\_ Group # \_\_\_\_\_  
 Employee  Dependents (please list) \_\_\_\_\_

Covers (please check):  Inpatient  Outpatient  Prescription  Vision Care  Dental  
 Other \_\_\_\_\_  Mental  Cancer  Accident  LTC  Work Comp

- If employment has ended, did insurance coverage end also?  Yes  No If yes, please list the individuals covered: \_\_\_\_\_

The above information was provided by: \_\_\_\_\_

**Signature and Title** of the Individual Completing this Form

Date

Please print your name and the name of the business

Business Telephone

Fax Number